W-1507A
(Rev. 3/00)
DUPL-CENTER

STATE OF CONNECTICUT - DEPARTMENT OF SOCIAL SERVICES

MODIFIED COMMUNITY CARE ASSESSMENT

Agency Use....

Referral Date.

Ref. by: (Code on last page).....

Date Assessed.

Date Reassess.

Last Name:

First Name, Int:

Address: _____

Town: Specify Name _____ Town Code.....

Telephone Number: _____ Zip Code

Date of Birth:.....

Sex: 1 Male 2 Female.....

Racial/Ethnic Background (see code on last page).....

Marital Status: (see code on last page).....

Social Security Number.....

Medicare No. A B

EMS / Medicaid (Title 19) Number:

Other Insurance _____

_____

_____

Court appointed conservator/guardian
Code: 1 Yes 0 No

If yes, specify name and relationship: _____

Recent History of Hospitalization/Institutionalization:

Date of most recent admission .....
(include other dates, location and admission diagnosis if known)

ICD-9 Code .

_____

_____

_____

INITIAL REASS

Do you (client) want to return/remain in community? ☐ ☐
Code: 1 Yes 0 No

(Respond in client's words)_____

_____

How is your health?
Code 1 good 3 poor
2 fair 9 information not obtained

Now ..... ☐ ☐

Before your admission (if applicable) ..... ☐ ☐

Primary Health Problem(s) related by client ☐ ☐
Code using the appropriate number from page 3 ☐ ☐
☐ ☐
☐ ☐

What assistance do you think you need?_____

_____

Current/Other Active Problems: Specify current treatment and symptoms including acute and chronic-unstable conditions (where possible this information should be obtained from existing medical record)
(Code using the appropriate number from page 3.) ☐ ☐
☐ ☐
☐ ☐
☐ ☐
☐ ☐

Past Health Problems (include physical/emotional problems and chronic-stable conditions)

☐ ☐
☐ ☐
☐ ☐
☐ ☐
☐ ☐

DIAGNOSES SECTION:
For MAJOR DIAGNOSIS, check the major conditions relating to the need for nursing home placement. For CONTRIBUTING DIAGNOSIS, check all that apply. In the NEW vs the CHRONIC column, write "N" or "C" for each diagnosis; NEW indicates a diagnosis as of this hospitalization or within the past month in the community or nursing home. Provide the date of onset for any new diagnosis. Provide specific information, when available, in the comments section.

DIAGNOSIS/HEALTH CONDITIONS	MAJOR DX	CONTRIBUTING DX	NEW OR CHRONIC	COMMENTS/DATE OF ONSET FOR NEW DX
1. CVA				
2. MYOCARDIAL INFARCTION				
3. CONGESTIVE HEART FAILURE				
4. OTHER HEART DISEASE				
5. HYPERTENSION				
6. HIP FRACTURE				
7. OTHER FRACTURE/INJURY				
8. RHEUMATOID/ OSTEOARTHRITIS				
9. OSTEOPOROSIS				
10. NEUROMUSCULAR DISEASE				
11. CANCER				
12. DIABETES				
13. BLOOD DISORDER or DISEASE				
14. EMPHYSEMA/COPD				
15. OTHER CHRONIC LUNG DISEASE				
16. DIGESTIVE DISORDERS				
17. URINARY TRACT DISORDERS				
18. DECUBITUS/STASIS ULCER				
19. AMPUTATION				
20. VISUAL IMPAIRMENT				
21. HEARING IMPAIRMENT				
22. ALZHEIMER'S/OTHER DEMENTIA				
23. MENTAL ILLNESS				
24. DEVELOPMENTAL DISABILITIES				
25. OTHER, SPECIFY:				

List Medications: name, dosage, frequency (include over the counter as well as prescription)

Note with check mark(s) below if any of these medications fall into group(s) with greater potential of serious side effects in elderly:

___ Analgesics/narcotics/muscle relaxants
___ Antihypertensive/diuretics/electrolytes
___ Hypoglycemics/insulin
___ Antianxiety/hypnotic
___ Antidepressants
___ Antipsychotic
___ Anti-Parkinsonian
___ Other (e.g. potential for serious effects from interaction of specific medications noted above)

Primary Language Spoken ☐

Code: 1 English, 2 Polish, 3 Italian, 4 Spanish, 5 French, 6 Other, 7 not asked/required, 8 equivocal, 9 information not obtained

INITIAL ☐ REASS ☐

Expressive Communication

Code:
1 speaks and is usually understood
2 speaks but is understood only with difficulty
3 uses only sign language, symbol board, or written communication
4 uses only gestures, grunts, or primitive symbols
5 does not convey needs
9 information not obtained

Receptive Communication ☐ ☐

Code:
1 usually understands oral communication
2 has limited comprehension of oral communication
3 understands by depending on lip reading, written materials, or sign language
4 understands only primitive gestures, expressions or environmental cues
5 does not understand

	INITIAL	REASS
How is your memory?	☐	☐

Code:
1 good 3 poor
2 fair 9 information not obtained

MSQ Ask the following questions in as natural a way as possible.
Code: 1 correct 0 incorrect 9 information not obtained

	INITIAL	REASS
What is today's date?.....	☐	☐
What is the month now?.....	☐	☐
What year is it?.....	☐	☐
What is your street address? (or what is the name of this place?).....	☐	☐
Where is this place located? (town).....	☐	☐
How old are you?.....	☐	☐
What month were you born?.....	☐	☐
What year were you born?.....	☐	☐
Who is the President of the U.S.?.....	☐	☐
Who was the President before him?.....	☐	☐

MSQ SCORE (code number incorrect: 0-10; 99=information not obtained ☐☐ ☐☐

Behavior Pattern
Code:
0 never 1 sometimes 2 frequently 3 daily 9 information not obtained

	Initial	Reass
Abusive or assaultive.....	☐	☐
Wandering	☐	☐
Unsafe or unhealthy hygiene or habits.....	☐	☐
Threats to health/safety, poor judgment.....	☐	☐
Other.....	☐	☐
Does the client require supervision due to this behavior?	☐	☐

ACTIVITIES of DAILY LIVING

	Initial	Reass
***TRANSFER** ind.or equip. only (1) person assist (.5) is (not) transferred (0) Who helps (specify) _____	☐	☐
***TOILETING** ind. or equip. only (1) person assist (.5) does not use (0) Who helps (specify) _____	☐	☐
***BATHING** ind. or equip. only (1) person assist (.5) is bathed (0) Who helps (specify) _____	☐	☐
***DRESSING** ind. or equip. only (1) person assist (.5) is not dressed (0) Who helps (specify) _____	☐	☐
***EATING/FEEDING** ind. or equip. only (1) person assist (.5) is fed (0) Who helps (specify) _____	☐	☐
STAIR CLIMBING ind. or equip. only (1) person assist (.5) does not use (0) Who helps (specify) _____	☐	☐
MOBILITY ind. or equip. only (1) person assist (.5) does not go out (0) Who helps (specify) _____	☐	☐
WALKING ind. or equip. only (1) person assist (.5) does not walk (0) Who helps (specify) _____	☐	☐
WHEELING walks or device only (1) person assist (.5) is (not) wheeled (0) Who helps (specify) _____	☐	☐
BOWEL (if indicated, specify device) cont. or self-care (1) occ. incontinence (.5) incont.not self-care (0) Who helps (specify _____	☐	☐
BLADDER (if indicated, specify device) cont. or self-care (1) occ. incontinence (.5) incont.not self-care (0) Who helps (specify) _____	☐	☐

INSTRUMENTAL ACTIVITIES of DAILY LIVING

	Initial	Reass

***MEDICINE**..... ☐ ☐

Do you take your own:
without help (1) with some help (.5)
given by others (0) Who helps (specify) _____

***MEAL PREPARATION AND PLANNING**..... ☐ ☐

Do you plan and prepare your own meals:
without help (1) with some help (.5)
prepared by others (0) Who helps (specify) _____

HOUSEWORK..... ☐ ☐

Cleaning, (for men may be upkeep)
without help (1) with some help (.5)
does not participate (0) Who helps (specify) _____

LAUNDRY..... ☐ ☐

Do you do your own:
without help (1) with some help (.5)
done by others (0) Who helps (specify) _____

TELEPHONING..... ☐ ☐

Do you use the telephone:
without help (1) with some help (.5)
does not use (0) Who helps (specify) _____

MONEY MANAGEMENT..... ☐ ☐

Do you handle your own money:
without help (1) with some help (.5)
does not handle (0) Who helps (specify) _____

TRAVEL FROM RESIDENCE..... ☐ ☐

Do you get to places out of walking distance:
without help (1) with some help (.5)
does not travel (0) Who helps (specify) _____

SHOPPING..... ☐ ☐

Do you go shopping:
without help (1) with some help (.5)
does not shop (0) Who helps (specify) _____

INITIAL REASS

Are you supposed to have a special diet? ☐ ☐
Code: 1 Yes 0 No 9 information not obtained
(Specify)_____

Allergies ☐ ☐
Code: 1 none 4 environmental
2 food related 5 seasonal
3 drug related 6 combination
9 information not obtained

If drug related, specify which drugs_____

_____

Vision ☐ ☐
Code: 1 normal or minimal loss 4 total blindness
2 moderate loss 9 not determined
3 severe loss
Specify device:_____

Hearing ☐ ☐
Code: 1 normal or minimal loss 4 total deafness
2 moderate loss 9 not determined
3 severe loss
Specify device:_____

Mood/Affect
Code: 1 no problem 2 moderate problem (but not daily)
0 serious problem (nearly every day)

Feeling lonely.....	☐	☐
Sleeping problem.....	☐	☐
Worried anxious.....	☐	☐
Irritable, easily upset.....	☐	☐
Loss of interest.....	☐	☐
Feeling depressed.....	☐	☐
Suicidal talk/wishes.....	☐	☐
Substance abuse.....	☐	☐
Number of serious problems noted.....	☐	☐

Major life changes (Crises) in Past Year

_____

_____

_____

Who is your support system?

Code Number of people (0 if no support)	Initial	Reass
Child	☐	☐
Spouse	☐	☐
Other relative	☐	☐
Neighbor/Friend	☐	☐
Landlord	☐	☐
Other (specify)	☐	☐

Supporter's Health:

Code: 1 good 3 poor
2 fair 7 not applicable
9 information not obtained

How is your spouse's health? ☐ ☐

How is your main supporter's health? ☐ ☐
(if different from spouse)

If widowed, date of spouse's death ☐☐ ☐☐ ☐☐

Main supporter's relationship ☐ ☐
(see code last page)

Emergency Contact

Relationship_____

Name_____

Address_____

_____

Phone Number (home)_____ (work)_____

How often do you see your children, relatives, neighbors and friends?

Code: 1 never, rarely 3 fairly often, regularly
2 sometimes 7 not applicable
9 information not obtained ☐ ☐

Specify all that apply_____

Initial ☐ Reass ☐

Usual Living Arrangements.....

Code:

1 alone
2 with spouse
3 with child(ren)
4 with spouse & child(ren)
5 with relatives (not children) (specify) _____
6 with others (non-relatives) (specify) _____
9 information not obtained

Housing..... ☐ ☐

Code:

01 apartment
02 boarding home
03 low income housing
04 own house
05 home of children or relatives
06 subsidized but not low income housing
07 elderly housing
08 foster home
10 home of aged
11 ICF
12 SNF
13 rest home with nursing supervision
14 other (specify) _____
15 trailer
16 own condominium
99 information not obtained

Environment

Cleanliness of environment (Describe specific conditions observed upon home visit)

_____

_____

_____

Are architectural barriers a problem? ☐ ☐

Code: 1 Yes 0 No

Specify _____

Environmental hazards? ☐ ☐

Code: 1 Yes 0 No

Specify _____

Prosthetic Devices

Code: 1 Yes 0 No 9 Other

Walker ..... ☐ ☐

Wheelchair ..... ☐ ☐

Other (specify)..... ☐ ☐

(e.g. cane, denture, pacemaker, other artificial body part or limb)

Financial Assistance - indicate status of each with appropriate code:

Code: 1 active 3 dropped 5 eligible but not partic.
2 pending 4 ineligible 9 information not obtained

	Initial	Reass.
Medicare (Title 18 part B)	☐	☐
Veterans Medical Benefits	☐	☐
Medicaid (Title 19)	☐	☐
State Supplement	☐	☐
Supplemental Security Income (S.S.I.)	☐	☐
Food Stamps	☐	☐
Fuel Assistance	☐	☐
Rental Rebate	☐	☐
Other, Specify	☐	☐

What is the anticipated outcome for the client in twelve months time? Indicate the appropriate code for initial assessment or reassessment, whichever applies. ☐ ☐

Code: 1 To become more independent
2 To remain at the same level of dependency
3 To become more dependent

Does client meet nursing home level of care? ☐ ☐
Code: 1 Yes 0 No

Signature of the Social Worker/Nurse, or person conducting the assessment:

_____

Agency: _____

Agency Code: ☐ ☐ ☐ ☐ ☐ ☐ ☐

Phone Number: _____ Date: _____

CODING FOR ASSESSMENT

Racial/Ethnic Background

1 White (non-minority)
2 Black (not Hispanic)
3 American Indian or Alaskan Native
4 Hispanic
5 Asian or Pacific Islander
6 Other (specify) _____

Marital Status

1 never married
2 married
3 separated
4 divorced
5 widowed
9 information not obtained

Source of Referral

01 self
02 relative/friend
03 info line
04 agency outreach
05 municipal agent
06 Access Agency
07 clergy/religious
08 senior center
09 legal services agency
10 social services agency
11 community health agency
12 nursing home/LTC facility
13 hospital
14 other
15 newspaper
16 doctor
17 DSS
99 info not obtained

Relationship of caregiver

1 spouse
2 child
3 parent
4 sibling
5 friend
6 other relative
7 other _____
8 no one providing assistance
9 information not obtained